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	495358	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/15/15 through 4/17/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements The Life Safety Code survey/report will follow. The census in this 100 bed certified facility was 96 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #17 and #23 through #25) and 5 closed record reviews (Residents #18 through #22).	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	RECEIVED MAY 01 2015 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Virginia M. Snead | Administrator | 4/29/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to provide personal privacy for two of six residents during the medication administration observation, Residents #13 and #14. 1. Resident #13 was administered an injection into the abdomen with her abdomen exposed while in the room with the door open. 2. Resident #14 was administered medication by mouth and choked in the dining room, while in the presence of other residents. The findings include: 1. Resident #13 was administered an injection into the abdomen with her abdomen exposed while in the room with the door open. Resident #13 was admitted to the facility on 3/20/13 with diagnoses that included but were not limited to: diabetes (elevated blood sugar), kidney disease and high blood pressure. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/15, coded the resident as being cognitively intact.	F 164	1. LPN #1 was given 1-1 counseling about providing privacy for residents receiving invasive medications or procedures and also asking residents prior to medication administration, where they would prefer to receive their oral medications. 04/21/15 2. All LPNS and RNs have received education on privacy during medication administration and asking the residents' preference on where they prefer their oral medication to be administered 04/29/15 3. A protocol for administration of medications to include privacy and residents preference has been reviewed by the QA Committee and approved. All LPNS and RNS have been educated on the new protocol. 04/29/15 4. Medication pour and pass observations will be conducted by the QA Nurse on a monthly basis and reported to the QA Committee quarterly.	

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On 4/16/15 at 8:12 a.m., observation of LPN (licensed practical nurse) #1 administering an injection into Resident #13's abdomen was conducted. The resident's shirt was pulled up, exposing a portion of her abdomen. The injection was administered in the resident's room with the door open. No privacy curtain was drawn. A housekeeping employee was observed mopping the floor in another resident room directly across the hall.

On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked the process for providing privacy while administering an abdominal injection. LPN #1 stated she gives injections in residents' rooms and she pulls the privacy curtain if someone else is in the room. LPN #1 was then asked if she leaves the door open. LPN #1 stated, "I should have shut the door."

On 4/16/15 at 12:55 p.m., an interview was conducted with Resident #13. The resident was asked how she felt about receiving an injection into her abdomen with the room door open. Resident #13 stated sometimes she doesn't like it.

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding privacy during medication administration.

2. Resident #14 was administered medication by

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mouth and choked in the dining room, while in the presence of other residents.

Resident #14 was admitted to the facility on 7/10/13 with diagnoses that included but were not limited to: high blood pressure and heart disease. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/14/15, coded the resident's cognition as being severely impaired.

On 4/16/15 at 8:00 a.m., observation of LPN #1 administering medication to Resident #14 in the dining room was conducted; other residents were present in the dining room. At this time, Resident #14 began coughing for approximately five seconds while attempting to swallow her pills. The resident was able to finish taking her medication after the coughing ceased.

On 4/16/15 at 10:30 a.m. a group interview was conducted with 13 residents. Three residents stated they receive medication in the dining room.

On 4/16/15 at 1:50 p.m., an interview was conducted with LPN #1. LPN #1 stated the nurses administer inhalers, nasal sprays and injections in resident rooms but usually administer pills in the dining room or day rooms if residents are okay with that. When asked how she knew if residents were comfortable with receiving pills in the dining room, LPN #1 stated the nurses will ask. LPN #1 confirmed she did not ask Resident #14 if she was comfortable receiving her medication in the dining room that morning.

On 4/16/15 at 2:20 p.m., an interview was conducted with Resident #14. At this time, this

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surveyor stated to the resident that she had been observed receiving her medication in the dining room that morning. Resident #14 stated, "Yeah, when I choked." Resident #14 was asked how she felt about receiving medication in the dining room. Resident #14 stated, "Everybody else is getting it too." When asked if she would prefer to get her medication in private, Resident #14 stated, "Yeah. Bring me back down here (to the room)."

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding privacy during medication administration.

F 167 SS=C — 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE

A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, it was

F 167

1. State Survey holder is now labeled State Survey and moved closer to front door so it will be easily accessible. — 04/29/2015
2. Notices will be placed in admission packet for families and residents as to location of state survey results. Activities Director will continue to bring up location of state survey results at every Resident Council Meeting. All residents will sign acknowledgment of location of survey. — 05/01/2015

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determined that the facility staff failed to post a notice regarding the availability of survey results

The findings include:

On 4/15/15 at 12:50 p.m. and 4/16/15 at 11:25 a.m., observation of the facility's 2014 survey results was conducted. The results were located in a green folder on the wall next to the entrance into the front lobby. The front of the folder was labeled, "2014." No further notice of the survey results was documented on the folder or anywhere else in the lobby.

On 4/16/15 at 10:30 a.m., a group meeting was conducted with 13 residents. When asked if they knew where the survey results were located, five residents stated, "Yes" and the other residents shook their heads.

On 4/16/15 at 11:50 a.m., an interview was conducted with CNA (certified nursing assistant) #1 regarding availability of survey results. CNA #1 stated the administrator kept the survey results in her office and staff could ask to look at them. When asked how residents and visitors had access to the survey results, CNA #1 stated, "I wouldn't know how to answer that." When asked if any notice of survey results was posted, CNA #1 stated, "In the employee lounge."

On 4/16/15 at 11:55 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated the survey results were located in the green folder at the door and residents were made aware of that during the resident council meetings.

F 167 3. Mandatory in-service will be given by QA/Administrator for all staff to ensure everyone knows where the most recent state survey is located. — 04/29/2015

4. Administrator will check weekly for placement of state survey to make sure it is easily accessible. — 05/01/2015

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F 167	Continued From page 6 On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. On 4/17/15 at 9:06 a.m., an interview was conducted with Resident #23. Resident #23 was admitted to the facility on 3/3/15 with diagnoses that included but were not limited to: high blood pressure, osteoporosis (a bone disease) and a urinary tract infection. Resident #23's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 4/1/15, coded the resident as being cognitively intact. Resident #23 stated she did not know where the survey results were located in the facility. On 4/17/15 at 9:16 a.m., an interview was conducted with Resident #25. Resident #25 was admitted to the facility on 5/2/14 with diagnoses that included but were not limited to: muscle weakness, urinary tract infection and breast cancer. Resident #25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/8/15, coded the resident as being cognitively intact. Resident #25 stated she did not know where the survey results were located in the facility. No further information was presented prior to exit.	F 167		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to implement abuse policies and procedures for abuse in regards to screening employees prior to hire for one of five employee records reviewed of new hires from the last four months; Other Staff Member (OSM) #4, Speech Language Therapist.

The facility was unable to evidence a license verification was obtained for OSM #4, who was hired on 1/26/15, until requested on survey (4/16/15).

The findings include:

On 5/29/14 a review of five employee records of new hires from the last four months was conducted. OSM #4's record did not contain a license verification from the Virginia Department of Health Professions website.

On 4/16/15 at 8:45 a.m., in an interview with the Administrator, she stated that the rehab (rehabilitation) company staffs the therapy department and do all the checks and screens. She stated the rehab facility provided them with a license verification but it was dated 4/16/15 and was not evidence it was done at the time of hire.

An email was provided from the rehab company that documented, "It is the practice of Human Resource to verify therapist have a clean license

1. 100% audit of all current therapy staff ensuring the implementation of abuse policies and procedures for abuse in regards to screening employees prior to hire. — 05/01/2015
2. All new hires for therapy will be screened according to policy and procedure for abuse and copy of license verification from the Virginia Department of Health Professions will be placed in file at facility in Rehab Directors office, this is to be signed off each time by Office Manager/HR at Amelia Nursing and Rehabilitation Center — 05/01/2015
3. In-service Therapy Company (Rehab Management, Inc) on importantance of proper screening of all new hires according to policy and procedure for prevention of abuse. In-service to be given by Business Office Manager/HR to HR and program manager of therapy company. — 04/29/2015
4. All present therapy staff and any new hire for therapy will be signed off by Amelia Nursing and Rehabilitation Center Business Office Manager /HR and Administrator. — 05/8/2015

(File to be kept by Program Manager)

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F 220	Continued From page 8 with no dings on it through the state Office of the Inspector General and preform (sic) a license Source Verification through Dept of Health as a condition of pre-employment. In the case of (OSM #4) the onboarding agent may have been somewhat overzealous and did not print the Source Verification Screen at the time of viewing. Under no circumstances can any candidate be keyed into the (system) employee system/data base without this verification being performed. (System) requires all new hire onboarding be audited by HR, any discrepancies in requirements would have been caught at that time if the employee had any red flags against their license..." A second email from the therapy company documented, "We always verify therapist have a clean license with no dings on it through the state Office of the Inspector General and a licensure Source Verification through Dept of Health as a condition of pre-employment and annually thereafter." A review of the facility policy "Screening of Potential New Hires" documented, "License and certified personnel shall have their license verified with the State Board of Nursing (sic) an area is available on the application to record verification." No further information was provided by the end of the survey.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241	1. LPN #1 was counseled 1-1 regarding the failure to administer medications to Residents #13 and #14 in a way that maintained their dignity and respect in full recognition of their individuality.	04/21/15

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F 241	Continued From page 9 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide dignity and respect for two of six residents during the medication administration observation. Residents #13 and #14. 1. Resident #13 was administered an injection into the abdomen with her abdomen exposed while in the room with the door open. When interviewed about this, Resident #13 stated sometimes she doesn't like it. 2. Resident #14 was administered medication by mouth and choked in the dining room, while in the presence of other residents. When asked if she would prefer to get her medication in private, Resident #14 stated, "Yeah. Bring me back down here (to the room)." The findings include: 1. Resident #13 was administered an injection into the abdomen with her abdomen exposed while in the room with the door open. Resident #13 was admitted to the facility on 3/20/13 with diagnoses that included but were not limited to: diabetes (elevated blood sugar), kidney disease and high blood pressure. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/15, coded the resident as being	F 241	2. All LPNs and RNs have received in-service education on resident dignity and respect of individuality. 04/29/15 3. A protocol for administration of medication has been instituted after review by the QA Committee. It outlines the necessity to allow the resident to make choices on where they will take their medications. As well as providing privacy for those residents receiving invasive procedures in order to maintain their dignity. All nurses have been educated on this protocol. 04/29/15 4. Medication pour and pass observations will be conducted monthly by the QA nurse and reported to the QA committee at the quarterly meetings. 04/29/15	

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cognitively intact.

On 4/16/15 at 8:12 a.m., observation of LPN (licensed practical nurse) #1 administering an injection into Resident #13's abdomen was conducted. The resident's shirt was pulled up, exposing a portion of her abdomen. The injection was administered in the resident's room with the door open. No privacy curtain was drawn. A housekeeping employee was observed mopping the floor in another resident room directly across the hall.

On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked the process for providing privacy while administering an abdominal injection. LPN #1 stated she gives injections in residents' rooms and she pulls the privacy curtain if someone else is in the room. LPN #1 was then asked if she leaves the door open. LPN #1 stated, "I should have shut the door."

On 4/16/15 at 12:55 p.m., an interview was conducted with Resident #13. The resident was asked how she felt about receiving an injection into her abdomen with the room door open. Resident #13 stated sometimes she doesn't like it.

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding dignity and respect during medication administration.

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2 Resident #14 was administered medication by mouth and choked in the dining room, while in the presence of other residents.

Resident #14 was admitted to the facility on 7/10/13 with diagnoses that included but were not limited to: high blood pressure and heart disease. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/14/15, coded the resident's cognition as being severely impaired.

On 4/16/15 at 8:00 a.m., observation of LPN #1 administering medication to Resident #14 in the dining room was conducted; other residents were present in the dining room. At this time, Resident #14 began coughing for approximately five seconds while attempting to swallow her pills. The resident was able to finish taking her medication after the coughing ceased.

On 4/16/15 at 10:30 a.m. a group interview was conducted with 13 residents. Three residents stated they receive medication in the dining room

On 4/16/15 at 1:50 p.m., an interview was conducted with LPN #1. LPN #1 stated the nurses administer inhalers, nasal sprays and injections in resident rooms but usually administer pills in the dining room or day rooms if residents are okay with that. When asked how she knew if residents were comfortable with receiving pills in the dining room, LPN #1 stated the nurses will ask. LPN #1 confirmed she did not ask Resident #14 if she was comfortable receiving her medication in the dining room that morning.

On 4/16/15 at 2:20 p.m., an interview was

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F 241	Continued From page 12 conducted with Resident #14. At this time, this surveyor stated to the resident that she had been observed receiving her medication in the dining room that morning. Resident #14 stated, "Yeah, when I choked." Resident #14 was asked how she felt about receiving medication in the dining room. Resident #14 stated, "Everybody else is getting it too." When asked if she would prefer to get her medication in private, Resident #14 stated, "Yeah. Bring me back down here (to the room)." On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding dignity and respect during medication administration.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278	1. RN #2 has reviewed the RAI Manual regarding the need for a mood interview for Resident #9. RN #2 voiced understanding for the need of an interview. 2. An audit of all current quarterly and annual MDS was completed by the MDS coordinator and MDS assistant in order to check for any other possible interview errors. 3. Both the MDS coordinator (RN #2) and the MDS assistant were in-serviced by the DON on ensuring a complete and accurate MDS is done by referring to RAI manual when in doubt.	04/27/15 04/29/15 04/27/15

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F 278	Continued From page 13 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate MDS (Minimum Data Set) for one of 25 residents in the survey sample, Resident # 9. The facility staff failed to conduct the resident interview for mood on a quarterly MDS (Minimum Data Set) assessment for Resident #9. The findings include: Resident # 9 was admitted to the facility on 8/9/13 with a readmitted on 9/14/14 with diagnoses that included but were not limited to: dementia (a group of symptoms caused by disorders that affect the brain), herpes simplex (infection that is caused by a herpes simplex virus), lumbar compression fracture (broken vertebrae) Vertebrae are the bones of the spine), esophageal reflux (when a muscle at the end of your esophagus does not close properly it allows stomach contents to leak back, or reflux, into the esophagus and irritate it), dysphagia (a swallowing disorder), acute respiratory failure	F 278	4. The QA Committee will review compliance at the quarterly meeting.	04/29/15

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(when not enough oxygen passes from your lungs into your blood).
The MDS (minimum dada set), a quarterly assessment had an ARD (assessment reference date) of 1/26/15. Section B0700 "Makes Self Understood" coded Resident # 9 as "Sometimes understood" and section B0800 "Able To Understand Others" coded Resident # 9 as "Sometimes understands."
Section D0100 documented, "Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents." A "0" (zero) was coded in the box under section D0100 that documented, "No (resident is rarely/never understood). Skip to and complete D0500-D0600, Staff Assessment of Resident Mood." Section D0300 "Total Severity Score" was blank. The staff assessment of resident mood was completed.
On 4/16/15 at approximately 3:30 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator regarding Resident # 9's missing interview for the mood section of the quarterly MDS assessment with the ARD of 1/26/15. After reviewing Resident # 9's quarterly MDS assessment with the ARDs of 1/26/15, RN #2 stated, "I was taught that you start with section C, cognition and if the resident couldn't complete that interview I wouldn't have to do the others."
When asked what guidance they follow for completing the MDS RN #2 stated, "We follow the RAI (Resident Assessment Instrument) manual."
Review of "CMS's (Centers for Medicare/Medicaid Services) RAI Version 3.0 Manual" documented,
"D0100: Should Resident Mood Interview Be Conducted?

Steps for Assessment

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F 278	Continued From page 15 1. Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). 2. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1). If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©)." The Administrator and DON were made aware of these findings on 4/16/15 at approximately 6:20 p.m. No further information was provided prior to exit.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1.Maintenance Director called O'Neal's Electrical to assist in finding thermostat adjustment dial on Hydrocullator after adjusting thermostat temperatures are running 160 degrees daily.	04/17/2015

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This REQUIREMENT is not met as evidenced by.
Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to maintain the hydrocollator (a device containing hot water and heating pads) temperature per the manufacturers' instructions, for four of 25 residents in the survey sample. Residents #3, #23, #24 and #25.

Observations of the hydrocollator temperature were 170 degrees. The manufacturers' instructions documented the recommended operating temperature of 160 to 166 degrees.

The findings include:

On 4/15/15 at 12:55 p.m., observation of the hydrocollator in the rehab department was conducted. At this time, OSM (other staff member) #1, a rehab (rehabilitation) technician was asked to take the temperature of the water inside of the hydrocollator. The thermometer read 170 degrees. OSM #1 was asked to provide a copy of the hydrocollator manufacturers' instructions.

On 4/16/15 at 11:30 a.m., another observation of the hydrocollator was conducted. At this time, OSM #1 was asked to take the temperature of the water inside of the hydrocollator. The thermometer read 170 degrees. When asked what the temperature was supposed to be, OSM #1 stated, "Anywhere between 160 degrees and

2. Temperature will be checked every morning and documented on temperature log by rehab staff. Any temperature above 166 degrees will be reported to Program Manager. — 04/17/2015

3. Program manager will in-service all Rehab staff on correct temperatures for Hydrocollator 160-166 degrees. Program Manager to be made aware of any temperatures higher than 166 degrees and Hydrocollator will be taken out of service immediately. — 04/29/2015

4. Daily Temperature log will be signed off by Program manager and Maintenance Director weekly. — 04/24/2015

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170 degrees."

On 4/16/15 at 11:45 a.m., an interview was conducted with OSM #2, the director of rehabilitation. OSM #2 was asked what the manufacturers' instructions were regarding the temperature of the hydrocollator. OSM #2 stated, "It varies between 160 degrees and 170 degrees." OSM #2 was shown the manufacturers' instructions that documented, "PRECAUTIONARY INSTRUCTIONS: 2. CAUTION: The thermostat is extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 (degrees Fahrenheit) to 166 (degrees Fahrenheit)..." OSM #2 stated, "Oh. It's been running 170 degrees and a little bit under." At this time, this surveyor requested the April 2015 hydrocollator temperature log and a list of residents who were receiving hot packs from the hydrocollator.

Review of the April 2015 hydrocollator temperature log revealed the following temperatures:

4/1/15- 171 degrees
4/2/15- 171 degrees
4/3/15- 171 degrees
4/6/15- 171 degrees
4/7/15- 171 degrees
4/8/15- 170 degrees
4/9/15- 170 degrees
4/10/15- 171 degrees
4/13/15- 171 degrees
4/14/15- 170 degrees
4/15/15- 171 degrees
4/16/15- 170 degrees

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Review of the list of residents receiving hot pack therapy revealed four residents were receiving hot packs. The following interviews were conducted with those residents:

Resident #3 was admitted to the facility on 5/25/13 with diagnoses that included but were not limited to: anxiety, osteoporosis (a bone disease) and muscle weakness. Resident #3's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 3/24/15, coded the resident's cognition as being moderately impaired. On 4/17/15 at 8:23 a.m., an interview was conducted with Resident #3. Resident #3 confirmed she was receiving hot pack therapy and stated the hot packs felt good.

Resident #23 was admitted to the facility on 3/3/15 with diagnoses that included but were not limited to: high blood pressure, osteoporosis and a urinary tract infection. Resident #23's most recent MDS, a 14 day Medicare assessment with an ARD of 4/1/15, coded the resident as being cognitively intact. On 4/17/15 at 9:06 a.m., an interview was conducted with Resident #23. Resident #23 confirmed she was receiving hot pack therapy and stated the hot packs felt good.

Resident #24 was admitted to the facility on 6/13/13 with diagnoses that included but were not limited to: osteoporosis and high blood pressure. Resident #24's most recent MDS, a quarterly assessment with an ARD of 1/30/15, coded the resident as being cognitively intact. On 4/17/15 at 9:15 a.m., this surveyor attempted to interview Resident #24 but the resident was involved in an activity.

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F 323	Continued From page 19 Resident #25 was admitted to the facility on 5/2/14 with diagnoses that included but were not limited to: muscle weakness, urinary tract infection and breast cancer. Resident #25's most recent MDS, a quarterly assessment with an ARD of 2/8/15, coded the resident as being cognitively intact. On 4/17/15 at 9:16 a.m., an interview was conducted with Resident #25. Resident #25 confirmed she was receiving hot pack therapy. Resident #25 stated the hot packs were a little warm at first but felt good after her legs got used to the weight and heat. On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. No further information was presented prior to exit.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by Based on observation, staff interviews and facility documentation review the facility failed to prepare	F 371	1a. All dietary staff provided hair restraints/nets to wear in the main kitchen during food prep and serve. Anyone not wearing proper hair restraints will not be allowed in the kitchen prep area. 1b. Meat Slicer taken apart and cleaned per procedure for cleaning meat slicer. 1c. fans immediately removed from kitchen and clean dust free fans in their places. Dietician to provide procedure for proper storage of food during preparation.	04/17/2015 04/16/2015 04/16/2015 04/27/2015

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F 371	Continued From page 20 and serve food in a sanitary manner. 1) Facility staff failed to wear hair restraints in the main kitchen during food preparation and serving. 2) Facility staff failed to properly clean food service equipment. 3) Facility staff failed to ensure uncovered food was free of dust and debris from a nearby fan. The findings include: 1) On 4/15/15 at 11:52 a.m., the kitchen tour was conducted. On 4/15/15 at 11:52 a.m., an observation was made that OSM (other staff member) # 3, the dietary manager was not wearing the appropriate hair restraint. On 4/16/15 at 11:45 a.m., an observation was made that OSM #3 was not wearing the appropriate hair restraint. On 4/16/15 at 12:00 p.m., OSM (other staff member) #4, a housekeeper entered the kitchen without wearing a hair net, picked up a tray of food from a preparation table and walked back out of the kitchen. On 4/16/15 at approximately 12:30 p.m. an interview was conducted with OSM # 4. When asked if she had entered the kitchen without wearing a hair net, OSM # 4 stated, "Yes. I stood in the doorway and asked for my tray and (OSM # 3), dietary manager told me to come into the kitchen and get my tray." On 4/16/15 at 12:32 p.m., an observation was made that a non-dietary staff member came into the kitchen during lunch preparation without a	F 371	2a. All entering kitchen will wear hair restraints/nets or stay out. Other staff ,families will pick up their trays from the kitchen window and whatever else they need out of the kitchen will be brought to them by dietary staff. (Signage will be placed on entrance doors to kitchen regarding this policy) 2b. Proper cleaning of all food service equipment will be maintained by dietary staff. Cook for each shift is responsible for proper cleaning. Dietary Manager or designee will check all equipment daily for cleanliness. 2c. Fans are not to be allowed in kitchen until cleaned and approved by maintenance. Fans will be removed weekly and checked/cleaned by maintenance per schedule. -Proper storage of food during preparation to be the responsibility of the cook.	04/27/2015 04/17/2015 04/16/2015

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F 371	Continued From page 21 hair restraint. On 4/16/15 at 12:45 p.m., a certified nursing assistant was observed coming into the kitchen to get tea without a hair restraint during lunch preparation. On 4/16/15 at 4:29 p.m., an interview was conducted with OSM #3. When asked why she was not wearing a hair restraint while in the kitchen she stated," Eighteen years ago when I worked at a different facility their policy stated I did not have to wear a hair restraint if my hair was up in a tight bun."When asked how long she had been working at this current facility she stated, "Thirteen years." A policy was requested on appropriate attire while preparing and serving food. On 4/16/15 at 5:00p.m., OSM #3 provided section 12 VAC 5-421-240 of the state regulation licensure handbook. This section titled, "Effectiveness of hair restraints" documented. "A. Except as provided under section B of this section, food employees shall wear their hair restraints, such as hats, hair coverings, or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. B. This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged food, hostesses, and wait staff of they present a minimal risk of contaminating exposed foods; clean equipment, utensils, and linens; and unwrapped single	F 371	3a. In-service for all staff regarding not entering kitchen area-must wait at door/window for whatever they need. Dietician to in-service dietary. QA to in-service nursing. Administrator to in-service Housekeeping, Laundry, Maintenance, and Rehab	04/29/2015
			3b. In-service for all dietary staff regarding proper cleaning of all food service equipment especially the meat slicer will be given by Dietician. Schedule for cleaning to be evaluated by Dietician at the time and recommendations made where necessary.	04/29/2015
			3c. In-service for dietary and maintenance regarding importance of cleaning fan weekly or sooner if needed and importance of using proper procedure of proper storage of food during preparation. In-service to be provided by Dietician.	04/29/2015
			4a. Dietary Manager, Dietician, and Administrator will check to make sure all dietary staff are wearing proper hair restraints/nets and that no unauthorized persons are entering the kitchen prep area.	04/30/2015
			b. Dietary Manager/designee daily will oversee cooks and cleanliness of all food service equipment and sign off on cleaning schedule. Dietician will do a weekly walk through and do the same.	04/27/2015

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F 371	Continued From page 22 service and single-use articles." On 4/16/15 at 5:30 p.m., the administrator was made aware of the above findings. 2) On 4/15/15 at 11:56 a.m., debris was observed was left on the blade of the meat slicer that was stored and ready for use. On 4/15/15 at 11:56 a.m., an interview was conducted with OSM #3. When asked if the meat slicer was clean and ready to be used she stated, "Yes." When shown the debris she stated," It has to be cleaned again." When asked to clarify is she had previously stated that the meat slicer was ready to be used she stated," Yes, that is what I said." When asked the cleaning schedule of the meat slicer she stated, "After every use." On 4/16/15 at 4:29 p.m., a procedure and cleaning schedule was requested for cleaning the meat slicer. The facility's procedure for cleaning the meat slicer documented that it should be cleaned immediately after use. "1. Turn off and disconnect. 2. Remove food tray by loosening the screw on the side of the slicer. 3. Remove rectangular glide by lifting out (may be necessary to use a little force). 4. Remove the shield that covers the blade; pull latch to remove the cover. 5. Wash all parts in hot soapy water. 6. Sanitize with accepted water. 7. Wipe of remaining parts thoroughly in hot detergent water.	F 371	c. Dietician will also note on weekly note fans are clean and free of debris and proper procedure is being used during food preparation.	05/01/2015

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8 Rinse thoroughly..."

The Main Kitchen cleaning schedule documented that the meat slicer should be cleaned after use.

On 4/16/15 at 5:30 p.m., the administrator was made aware of the above findings.

3) On 4/15/15 at 12:15 p.m. it was observed that two ladder racks containing 14 trays were placed in front of a circulating fan that was covered in dust. All trays contained cups of uncovered peaches.

On 4/15/15 at 12:21 p.m., OSM # 3 was asked to turn off the fan and describe what she sees. She stated, "I can tell you it is dirty before I turn it off." She then pulled the cord from the outlet to shut off the fan. When asked to describe what she sees she stated, "Yes it needs to be cleaned. Maintenance comes in once a week to clean." When asked if the trays with cups of uncovered food items in front of the dusty fan are a problem she stated, "Yes."

On 4/15/15 at 12:45p.m, it was observed that the two ladder racks of 14 trays had been moved away from the fan.

On 4/16/15 at 4:29 p.m., a procedure was requested on proper storage of food during preparation.

On 4/16/15 at 5:00 p.m., a procedure could not be provided on proper storage of food during preparation

On 4/16/15 at 5:30p.m., the administrator was

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F 371	Continued From page 24 made aware of the above findings.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure the pharmacy wrote the monthly medication regimen review in the clinical record for 1 of 25 residents in the survey sample, Resident #5. For Resident #5, the pharmacy failed to write the monthly medication regimen review for November 2014 in the clinical record. The findings include: Resident #5 was most recently readmitted on 1/22/15 with the diagnoses of but not limited to stroke, pneumonia, metabolic encephalopathy, urinary retention, dysphagia, aphasia, diabetes, high blood pressure, and acute renal failure. The most recent MDS (Minimum Data Set) was a	F 428	1. A discussion by the DON with the consultant pharmacist and the IT department at Omnicare revealed that the consultant pharmacist had reviewed Resident #5 medications regime but had failed to check a block on the form that would generate a report therefore, Resident #5's name was left off the original list of residents seen by the pharmacist on November 25, 2014. The consultant pharmacist then failed to document in the progress notes because the name was not on her original list. 2. The facility changed pharmacy providers in November 2014 after APEX Pharmacy went out of business. All medications regime reviews were audited from November 2014 to April 2015 by the DON and QA nurse to ensure all reviews had been completed. 3. All Medications regime review lists generated by the consultant pharmacist will be audited for accuracy and to ensure all residents are reviewed by the DON or Designee.	04/23/15 04/29/15 04/27/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8530 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 25 quarterly assessment with an ARD (Assessment Reference Date) of 2/3/15. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for transfers, eating, and bathing; extensive assistance for dressing; as having a catheter for bladder and as incontinent of bowel. A review of the clinical record failed to reveal a note from the pharmacy indicating the monthly medication regimen review had been conducted for November 2014. On 4/16/15 at approximately 10:00 a.m., the Director of Nursing (DON) was asked for evidence the pharmacy reviewed the record in November 2014. A "Consultation Report" listing all residents records that were reviewed on 11/25/14 was provided. The list was in alphabetical order by last name and Resident #5 was not on the list. On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. On 4/17/15 at approximately 10:00 a.m., the Director of Nursing (DON) provided a second list that was sent to them by the pharmacy after the facility was notified there was no evidence the pharmacy reviewed Resident #5's drug regimen in November 2014. The second list also identified the residents seen on 11/25/14 as the first list had, only now the second list included the name of Resident #5. When asked about the discrepancy between the lists if the pharmacy saw the resident or not, the DON did not know why the two lists provided by pharmacy were not in agreement regarding who the pharmacy did or did not review on 11/25/14. When interviewed regarding evidence of a note in	F 428	4. The consultant pharmacist will report to QA committee quarterly on the number of MRRs completed as compared to census for the previous quarter.	04/29/15

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F 428	Continued From page 26 the clinical record that the review was conducted. The DON stated she didn't have anything else. A review of the facility policy "Medication Regimen Review (MRR)" documented, "1. The Consultant Pharmacy will conduct MRRs if required under a Pharmacy Consultant Agreement." Hand written under this was documented, "Contract requires monthly MRRs on all residents." No further information was provided by the end of the survey.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	Part 2 1. Ice scoop now being properly stored when not in use. Ice holder attached to ice machine. 2. All ice scoops checked for proper storage when not in use by Dietician, dietary manager or designee daily. Initial off on cleaning schedule. 3. In-service of all dietary staff regarding proper storage of ice scoop will be provided by dietician. 4. Ice scoop to be checked daily for proper storage when not in use by dietician staff and weekly by Dietician. Part 1 1. The QA nurse returned from her medical absence and the DON reviewed the deficient practice with the QA nurse regarding the infection control log.	04/27/15 04/27/15 04/27/15 04/27/15 04/23/15

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F 441	Continued From page 27	F 441	Cont Part 1	

communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a complete infection control program as evidenced by incomplete infection control tracking logs from March 2014 through August 2014; and failed to follow infection control practices for 1 of 3 facility ice machines, and failed to follow infection control practices for 2 of 6 residents in the medication administration observation; Residents #13 and #14.

1. The facility failed to maintain complete infection control tracking logs from March 2014 through April 2015, the logs did not include documentation of date of infection identified, resolved dates, cultures, signs/symptoms, or any type of isolation precautions utilized if necessary. In addition there was no log provided at all for the months of July and August 2014.

2. Facility staff failed to ensure proper storage of an ice scoop in 1 of 3 facility ice machines

2. A new tracking log tool has been developed to include resident name, age, unit, room #, admission date, attending M.D. date infection identified, resolved date, diagnosis, infections site, signs and symptoms, cultures/diagnostic test, antibiotic used, pertinent remarks, isolation (if any) invasive procedures, risk factors, resident outcome, preventive measures, This will be completed by the infection control nurse or designee. — 4/27/15

3. The infection control nurse will provide an infection report and tracking and trending to the DON on a monthly basis. — 04/29/15

4. The QA Committee will monitor the infections control reports quarterly. — 04/29/15

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F 441	Continued From page 28 (kitchen).	F 441	Part 3	

The findings include:

1 Review of the facility "Infection Control Log" for March 2014 through April 2015 revealed the following: From March 2014 through August 2014, nurse's note paper was used as the log format, on which was documented room number, first initial, last name, antibiotic used and the diagnosis the antibiotic was prescribed for. There were no specific column and headings of any kind marked and identified. There was no documentation of date of infection identified, resolved dates, cultures, signs/symptoms, or any type of isolation precautions utilized if necessary. In addition there was no log provided at all for the months of July and August 2014.

On 4/16/15 at 3:03 p.m., in an interview with the DON (Director of Nursing) she stated that the infection control nurse was out for health reasons; and she was not aware of the tracking method that was being utilized until the logs were requested by surveyors. She stated that since the infection control nurse was out and unable to answer for herself, she was not going to say anything more about it.

A review of the facility policy "Surveillance for Nosocomial Infections" documented, "Procedure...4. Collect the following data as appropriate, (Note: "*" indicates required information.): a. identifying information (i.e.: resident's name, age, room number, unit and attending physician); b. Diagnosis (resident may have many, list all that apply), c. Admission date, date of onset of infection" (may list onset of

1.	LPN # 1 received 1-1 counseling regarding her failure to maintain infections control standards while administering medications.	04/21/15
2.	Infection control standards for medication administration were reviewed with the LPNs and RNs by the DON.	04/27/15
3.	Monthly medication pour and pass will be monitored by the QA nurse and the pharmacy consultant nurse.	04/29/15
4.	The QA committee will monitor the monthly results at the quarterly meeting.	04/29/15

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symptoms, if known, or date of positive diagnostic tests); d. Infection site' (be as specific as possible, i.e., cutaneous infections should be listed as "decubitus, left foot", pneumonia as "RUL (right upper lobe), etc.); e. Pathogens"; f. Invasive procedures or risk factors (i.e.; surgery, invasive tubes, Foley, etc., fractured hip, malnutrition, altered mental status, etc.); g. Pertinent remarks (supportive information, i.e.; temperatures, other symptoms of specific infection, white blood cell count, etc.) Note: Change in mental status is often the only precursor to infection in the resident. Also record if the resident is admitted to the hospital, or expires. h. Preventive measures and comments' (interventions, steps taken that might have decreased risk, or would do so in the future (i.e.; barrier techniques, efforts to prevent immobilization, head elevated during tube feedings, resident non-compliance, etc.)).

On 4/17/15 at 8:45 a.m., the Administrator was made aware of the above findings. No further information was provided by the end of the survey.

2. Facility staff failed to ensure proper storage of an ice scoop in 1 of 3 facility ice machines (kitchen).

On 4/15/15 at 11:52 a.m., the kitchen tour was conducted. On 4/15/15 at 11:59 a.m., an ice scooper was observed sitting on top of the ice in the kitchen ice machine.

On 4/15/15 at 11:59 a.m., an interview was conducted with OSM (other staff member) # 3, the dietary manager. When asked if the ice scooper should be stored on the ice in the ice

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machine, she stated, "Yes, the county health department told us to keep the scooper speared into the ice throughout the day. At the end of the day we sanitize and put it in a zip lock bag." When asked to provide clarification on storage of the ice scoop she stated," I will do my best to provide documentation."

On 4/15/15 at 12:49 p.m., OSM # 3 could not provide documentation on proper storage of ice scoops. She provided a number for the county health inspector. When asked if OSM # 3 knew the federal regulation on proper storage of ice scoops, she stated, "Well I don't know that regulation."

On 4/16/15 at 12:40 p.m., an observation was made that the ice scooper was lying on top of the ice in the ice machine (kitchen).

On 4/16/15 at 1:00 p.m., a dietary aide opened the ice machine, grabbed the ice scooper, filled a pitcher of ice and then placed the ice scoop on top of the ice in the ice machine.

According to the 2013 FDA regulation 3-304.12: In Use Utensils, Between Use Storage,

"During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored:

(E) In a clean, protected location of the UTENSILS, such as ice scoops, are used only with a FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD.

43. In-use utensils: properly stored

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Based on the type of operation, there are a number of methods available for storage of in-use utensils during pauses in food preparation or dispensing, such as in the food, clean and protected, or under running water to prevent bacterial growth. If stored in a container of water, the water temperature must be at least 135 degrees Fahrenheit. In-use utensils may not be stored in chemical sanitizer or ice between uses. Ice scoops may be stored handles up in an ice bin except for an ice machine."

On 4/16/15 at 5:30 p.m., the administrator was made aware of the above findings. No further documentation was provided at that time.

3. LPN (licensed practical nurse) #1 dropped a pill on the medication cart, picked the pill up with her bare hand, placed the pill in a medication cup and administered the pill to Resident #13.

Resident #13 was admitted to the facility on 3/20/13 with diagnoses that included but were not limited to: diabetes (elevated blood sugar), kidney disease and high blood pressure. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/15, coded the resident as being cognitively intact.

On 4/16/15 at 8:12 a.m., observation of LPN #1 preparing and administering medication to Resident #13 was conducted. During preparation, LPN #1 dropped a pill on the medication cart, picked the pill up and placed the pill into a medication cup; the pill (in addition to other pills) was administered to Resident #13.

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On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done when a pill is dropped on the medication cart. LPN #1 stated the nurse should dispose of the pill and get another pill. LPN #1 confirmed she administered Resident #13 a pill she had dropped on the medication cart that morning.

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding the above findings.

4. LPN (licensed practical nurse) #1 dropped a pill on the medication cart, picked the pill up with her bare hand, placed the pill in a medication cup and administered the pill to Resident #14.

Resident #14 was admitted to the facility on 7/10/13 with diagnoses that included but were not limited to: high blood pressure and heart disease. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/14/15, coded the resident's cognition as being severely impaired.

On 4/16/15 at 8:00 a.m., observation of LPN #1 preparing and administering medication to Resident #14 was conducted. During preparation, LPN #1 dropped a pill on the medication cart, picked the pill up and placed the pill into a medication cup; the pill (in addition to other pills) was administered to Resident #14.

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F 441	Continued From page 33 On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done when a pill is dropped on the medication cart. LPN #1 stated the nurse should dispose of the pill and get another pill. LPN #1 confirmed she administered Resident #14 a pill she had dropped on the medication cart that morning. On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments, the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for one of 25	F 514	1. RN# 3 and LPN#2 were interviewed regarding the conflicting documentation on Resident #2 flu and pneumovac records under resident documents and in Resident #2 progress notes and observation sheet in the electronic chart. LPN#2 stated she had signed in error. The document was corrected by LPN #2 as a documentation error. Resident #2 refused both vaccines. 2. RN #3 did a 100% audit of all flu and pneumovac given in 2014 to ensure appropriate documentation. 3. The protocol for the flu and pneumovac documentation will limit documentation to the electronic nursing progress notes and the electronic form titled Influenza/Pneumococcal Immunization Observation Report.	04/17/15 04/22/15 04/20/15

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F 514	Continued From page 34 residents in the survey sample, Resident # 2. For Resident # 2 the facility staff failed to accurately document the influenza and pneumococcal immunizations. The findings include: Resident # 2 was admitted to the facility on 11/27/12 with a readmitted on 12/1/14 with diagnoses that included but were not limited to: hypertonicity of the bladder (increased muscle tone of the bladder), difficulty walking, muscle weakness, nasal bone fracture, abdominal aortic aneurysm (a bulge or "ballooning" in the wall of an artery), osteoporosis (makes your bones weak and more likely to break), hypertension (high blood pressure), coronary artery disease (common type of heart disease) and dementia (a group of symptoms caused by disorders that affect the brain). Review of Resident # 2's electronic clinical record revealed "(Name of Facility) Vaccine Record." Under "Pneumo (pneumococcal)-Vaccine" it documented the date given, "9/14 (September 2014)." Under "Flu (influenza) Vaccine" it documented the date given, "11/14 (November 2014)." Further review of Resident # 2's electronic clinical record revealed two "Influenza/Pneumococcal Immunization Observation Report." The "Influenza/Pneumococcal Immunization Observation Report" dated 9/25/2014 documented, "Resident refused pneumo (pneumococcal) vaccine at this time. Resident educated on pneumo vaccine and the importance of receiving it. She stated, 'Go away. I don't care what you say. Leave. Leave me alone.'" The "Influenza/Pneumococcal Immunization Observation Report" dated 11/24/2014 documented, "Resident returned from hospital stay on 11/21/14. Offered flu (influenza) vaccine	F 514	4. The QA Committee will monitor vaccinations at the quarterly meetings.	04/29/15

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upon return from the hospital. Resident refused flu vaccine at that time."
The "Resident Progress Note" dated 9/25/2014 at 11:20 a.m. for Resident # 2 documented, "Resident refused pneumo vaccine at this time. Resident educated on pneumo vaccine and the importance of receiving it. She stated, 'Go away. I don't care what you say. Leave. Leave me alone.'"
The "Resident Progress Note" dated 11/24/2014 at 9:33 a.m. for Resident # 2 documented, "Resident returned from hospital stay on 11/21/14. Offered flu (influenza) vaccine upon return from the hospital. Resident refused flu vaccine at that time."
On 4/17/15 at 8:45 a.m. an interview was conducted with RN (registered nurse) # 3. When asked who tracked the immunizations RN # 3 stated, "I do." When asked about the discrepancy of the two immunization records for Resident # 2, RN # 3 stated, "(Resident # 2) refused the vaccines." When asked about the "(Name of Facility) Vaccine Record" that documented Resident # 2 received the immunizations, RN # 3 stated, "It was documented in error by (LPN [licensed practical nurse] # 2).

On 4/17/15 at 8:50 a.m. an interview was conducted with LPN # 2. LPN # 2 stated she had documented that Resident # 2 had received the influenza and pneumococcal vaccines in error.
The facility's policy "Medical Records" documented in part, "All records are complete and accurate."
The Administrator and DON were made aware of these findings on 4/17/15 at approximately 10:00 a.m.

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F 514	Continued From page 36 No further information was provided prior to exit.	F 514		